FINAL
MEDICARE PART D
REPORTING REQUIREMENTS

Updated: 04/18/2005

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Introduction

In December 2003, Congress passed the Medicare Prescription Drug Benefit, Improvement and Modernization Act (MMA), allowing coverage of outpatient prescription drugs under the new Medicare Part D benefit. In accordance with Title I, Part 423, Subpart K (§ 423.514), the Act requires each Part D Sponsor to have an effective procedure to provide statistics indicating:

1) the cost of its operations
2) the patterns of utilization of its services
3) the availability, accessibility, and acceptability of its services
4) information demonstrating it has a fiscally sound operation
5) other matters as required by CMS

The purpose of this document is to provide an overview of CMS's proposed reporting requirements. This document represents our current expectations of data elements to be reported by Part D Sponsors at the distinct Plan level (i.e., data will be reported for each Plan offered under each Part D Contract) unless otherwise specified, reporting timeframes, and monitoring of Part D sponsors. According to Subpart O, sanctions may be imposed on Part D Sponsors who fail to comply with these reporting requirements.

The goal is to assure a common understanding of reporting requirements and how these data will be used to monitor the prescription drug benefit provided to Medicare beneficiaries. This document is final and reflects input and clarifications made from industry and government comments. These requirements will be in effect for Contract Year 2006 and are subject to change at the discretion of CMS.

The following criteria were used in selecting reporting requirements:

1) Minimal administrative burden on Part D Sponsors
2) Legislative and regulatory authority
3) Validity, reliability, and utility of data elements requested
4) Wide acceptance and current utilization within the Industry

Reporting requirements are described in this document for the following areas: Enrollment and Disenrollment, Reversals, Medication Therapy Management, Generic Dispensing Rate, Grievances, Prior Authorization/Step Edits/Non-Formulary Exceptions, Appeals, Call Center Measures, Overpayment, Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions, and Licensure and Solvency.

Previous CMS guidance documents have also stated that each Part D Sponsor shall provide necessary data to CMS to support payment, program integrity, program management, and quality improvement activities. Specifically, additional reporting requirements are identified in separate guidance documents for the following areas: formulary, TrOOP, coordination of benefits, payment and 1/3 audit, employer subsidy, low income subsidy, and Fallbacks.

Part D Sponsors may also be required to submit other information as defined by requirements in the application, guidances, or other documents (for example: pharmacy access, formularies, and P&T membership) during the annual contract bidding, application, or renewal process. Information is also required to be submitted throughout the contract year as allowable changes are made (e.g., formulary additions, P&T member changes, etc).

Part D Sponsor Reporting Requirements

In each of the sections that follow, the method of submission (e.g. entered into or uploaded via the Health Plan Management System (HPMS)) and the level of reporting are specified following the reporting timeline. Sections that refer to prescriptions should encompass all drugs, including compounded drugs.

For PACE Organizations offering Part D coverage, reporting requirements will be limited to: Section I. Enrollment/Disenrollment; Section IV. Generic Dispensing Rate; Section VI. Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions (for PACE Organizations utilizing formularies); Section IX. Overpayment; and Section X. Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions.

MA-PD Organizations will be required to comply with all reporting requirements contained herein, with the exception of those found in Section XI. Licensure and Solvency, Business Transactions and Financial Requirements.

Section I. Enrollment/Disenrollment

Title I, Part 423, Subpart B includes statutory regulations regarding beneficiary eligibility and enrollment. CMS will request enrollment data as part of the monitoring of a Plan's availability, accessibility, and acceptability of its services. Part D Sponsors will be responsible for reporting multiple data elements related to beneficiary enrollment at the Plan level.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the HPMS at the Plan level:

A. Number of beneficiaries enrolled in the Plan as of the end date of the reporting period identified above. This should be a numeric field.
B. Number of beneficiaries who disenrolled for any reason from the Plan any time during the reporting period identified above. This should be a numeric field.
C. Number of beneficiaries who were involuntarily disenrolled from the Plan for failure to pay their premium during the reporting period identified above. Please refer to 423.44 (d) (1) for exact definitions and requirements. This should be a numeric field.
D. Number of beneficiaries who were involuntarily disenrolled from the Plan for disruptive behavior during the reporting period identified above. Please refer to 423.44 (d) (2) for exact definitions and requirements. This should be a numeric field.
E. Number of beneficiaries who were disenrolled from the Plan for providing false or incomplete information regarding other coverage. This should be a numeric field.
F. Number of beneficiaries who were disenrolled from the Plan because of death during the reporting period identified above. This should be a numeric field.
G. Number of beneficiaries who were disenrolled from the Plan because of moving from the service area during the reporting period identified above. This should be a numeric field.

Section II. Reversals

Part D Sponsors will be responsible for reporting data elements related to claim reversals. Information on claim reversals will serve as a component in the monitoring of operational functions of Part D programs.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the HPMS at the Plan level:

A. Provide the total number of out-of-cycle pharmacy transactions with reversal as the final disposition, which were adjudicated during the time period specified above. This should be a numeric field.

Note: Reversed claim records must be maintained (the number of elements retained per record should at a minimum be equivalent to those of the prescription drug event record), and upon request, submitted to CMS.

Section III. Medication Therapy Management Programs

The requirements stipulating that Part D Sponsors provide Medication Therapy Management Programs (MTMP) are described in Title I, Part 423, Subpart D, § 423.153. For monitoring purposes, Part D Sponsors will be responsible for reporting several data elements related to their MTMP.

Data related to the identification and participation in the MTMP will be submitted according to the following timeline (note: Period 2 encompasses one full year):

	Period 1	**Period 2**
Reporting Period	January 1 - June 30	January 1 - December 31
Data due to CMS/HPMS	August 31	February 28

Data elements to be entered into the HPMS at the Plan level:

A. The number of beneficiaries who met the criteria for the MTMP in the specified time period above. This will be a numeric field.
B. The number of beneficiaries who participated (as defined by the Part D Sponsor) in the MTMP at any point during the time period specified above. This should be a longitudinally cumulative total. This will be a numeric field.
C. The number of beneficiaries who disenrolled (as defined by the Part D Sponsor) from the MTMP at any time during the specified time period above. This will be a numeric field.
D. The number of beneficiaries who declined the offer to participate in the MTMP during the specified time period above. This will be a numeric field.
E. For each beneficiary participating in the MTMP as of the last day of the reporting period specified, provide the total prescription cost of all medications on a per MTMP beneficiary per month basis. This will be a currency field. The total prescription cost should include MTMP beneficiary cost sharing and Part D Sponsor costs paid, exclusive of premiums or rebates, and should be calculated as follows: (AWP – network discounts + tax + dispensing fee). This amount should be summed for all prescriptions that were dispensed within the reporting period specified for each beneficiary participating in the MTMP as of the last day of the reporting period specified. Finally, this sum should be divided by the total number of member months for the included beneficiaries. These member months should include all months enrolled in the Part D Plan during the reporting period specified, not only the months that the beneficiary participated in the MTMP.

   The following equation also describes this calculation:

$$\left[\begin{array}{l}\text{Total prescription cost}\\ \text{per MTMP beneficiary}\\ \text{per month}\end{array}\right] = \frac{\sum_{i}^{n}\left(\sum_{\text{j}}^{\text{m}}(\text{AWP} - \text{network discounts} + \text{tax} + \text{dispensing fee})\right)}{\sum_{i}^{n}(\text{Member Months in Reporting Period})}$$

$\{\text{For beneficiaries } i \text{ to } n, \text{ and prescriptions } j \text{ to } m \text{ from the } i^{\text{th}} \text{ beneficiary}\}$

Section IV. Generic Dispensing Rate

Cost control requirements for Part D Sponsors are presented in Title I, Part 423, Subpart D. Accordingly, Part D Sponsors will be responsible for reporting data elements needed to monitor utilization of generic drugs (defined by Title I, Part 423, Sub-Part A, § 423.4).

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the HPMS at the Plan level:

A. Number of paid claims for generic drugs (regardless of days supply) with dates of service during the specified reporting period identified above. First DataBank or Medispan generic drug classifications will be used to identify generic drugs. This should be a numeric field.
B. Total number of paid claims (regardless of days supply) with dates of service during the specified reporting period identified above. This should be a numeric field.

Section V. Grievances

Title I, Part 423, Subpart M of the regulation includes statutory regulations that require Part D Sponsors to maintain grievance information. Plans will be responsible for reporting data related to grievance received.

A grievance is defined as any complaint or dispute, other than one that involves a coverage determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D Sponsor, regardless of whether remedial action is requested. Examples of subjects of a grievance provided in the solicitation for applications include, but are not limited to, timeliness, appropriateness, access to, and/or setting of services provided by the PDP sponsor, concerns about waiting times, demeanor of pharmacy or customer service staff, a dispute concerning the timeliness of filling a prescription or the accuracy of filling the prescription.

Part D Plans are required by the regulations to track and maintain records on all grievances received, both orally and in writing. Grievance data, requested herein by CMS, should be reported based on the date the grievance was received by the Part D Plan, not the date of the event or incident that precipitated the grievance occurred. Multiple grievances by a single complainant should be tracked and followed as separate grievances.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the HPMS at the Plan level:

A. For the time period identified above, provide the number of fraud and abuse grievances received related to Part D. A fraud grievance is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Part D Plan, or beneficiary engaged in the intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. An abuse grievance is a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Part D Plan, or beneficiary engaged in behavior that the individual should have known to be false, and the individual should have known that the deception could result in some unauthorized benefit to himself/herself or some other person. This should be a numeric field.
B. For the time period identified above, provide the number of enrollment/disenrollment grievances received related to Part D. Examples include, but are not limited to, discrimination in the enrollment process, enrollment information or and identification cards not being received by beneficiaries in a timely manner, and disenrollment requests not being processed in a timely manner. This should be a numeric field.
C. For the time period identified above, provide the number of benefit package grievances received related to Part D (benefit package grievances includes formulary and pricing/co-insurance issues). Examples include, but are not limited to, drugs not on formulary and beneficiary cost sharing. This should be a numeric field.
D. For the time period identified above, provide the number of pharmacy access/network grievances received related to Part D. Examples include, but are not limited to, network pharmacy refusing to accept beneficiaries card and network/non-network pharmacy concerns. This should be a numeric field.
E. For the time period identified above, provide the number of marketing grievances received related to Part D. Examples include, but are not limited to, marketing materials or promotional messages

by sales representatives that include misrepresentations or false/misleading information about plans and benefits and discriminatory practices identified in marketing materials or through oral/written promotional messages. This should be a numeric field.

F. For the time period identified above, provide the number of customer service grievances received related to Part D. Examples include, but are not limited to, grievances regarding services provided by the pharmacist/pharmacy staff, plan or subcontractor representatives, or customer service representatives. This should be a numeric field.
G. For the time period identified above, provide the number of confidentiality/privacy grievances received related to Part D. Examples include, but are not limited to, potential violations of medical information privacy standards by the plan or pharmacy. This should be a numeric field.
H. For the time period identified above, provide the number of other grievances received related to Part D. Examples include, but are not limited to, quality issues, appeals not handled on a timely basis, and any grievances that do not fall into one of the categories described above. This should be a numeric field.

Section VI. Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions

Title I, Part 423, Subpart D includes statutory regulations regarding drug utilization management programs. Part D Plans that utilize prior authorization or step therapy edits as utilization management tools (including for non-formulary exceptions) will be responsible for reporting several data elements related to these activities.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the HPMS at the Plan level:

A. Number of pharmacy transactions rejected due to failure to complete step therapy edit requirements in the time period specified above. This will be a numeric field.
B. Number of pharmacy transactions rejected due to need for prior authorization (not including first pass step therapy edits or early refills) in the time period specified above. This will be a numeric field.
C. Number of prior authorizations requested for formulary medications in the time period specified above (not including first pass step therapy edits or early refills). This will be a numeric field.
D. Number of prior authorizations approved for formulary medications in the time period specified above (not including first pass step therapy edits or early refills). This will be a numeric field.
E. Number of prior authorizations requested for non-formulary medications in the time period specified above (not including early refills). This will be a numeric field.
F. Number of prior authorizations approved for non-formulary medications in the time period specified above (not including early refills). This will be a numeric field.
G. Number of prior authorizations requested for tier exceptions in the time period specified above (not including first pass step therapy edits or early refills). This will be a numeric field.
H. Number of prior authorizations approved for tier exceptions in the time period specified above (not including first pass step therapy edits or early refills). This will be a numeric field.

Section VII. Appeals

Title I, Part 423, Subpart M includes statutory regulations regarding coverage determinations and appeals under Part D. As defined in §423.560, an appeal is any of the procedures that deal with the review of adverse coverage determinations made by the Part D Sponsor on the benefits under a Part D Plan the enrollee believes he or she is entitled to receive, including delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage. These procedures include redeterminations by the Plan and reconsiderations by the independent review entity (IRE).

CMS will request appeal data as part of the monitoring of a Plan's availability, accessibility, and acceptability of its services.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the HPMS at the Plan level:

A. Number of appeals submitted for **standard** redetermination in the time period specified above. This should be a numeric field.
B. Number of appeals submitted for **expedited** redetermination in the time period specified above. This should be a numeric field.
C. Number of appeals submitted for **expedited** redetermination that were granted **expedited** status. This should be a numeric field.
D. Number of appeals submitted for **standard** redetermination withdrawn by the enrollee. This should be a numeric field.
E. Number of appeals submitted for **expedited** redetermination withdrawn by the enrollee. This should be a numeric field.
F. Number of redeterminations resulting in reversal of original decision. This should be a numeric field.
G. Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **coverage determination**. This should be a numeric field.
H. Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **redetermination**. This should be a numeric field.
I. Number of IRE decisions for **standard** reconsideration resulting in reversal of original coverage determination or redetermination. This should be a numeric field.
J. Number of IRE decisions for **expedited** reconsideration resulting in reversal of original coverage determination or redetermination. This should be a numeric field.
K. Number of IRE decisions for **standard** reconsideration resulting in upholding of original coverage determination or redetermination. This should be a numeric field.
L. Number of IRE decisions for **expedited** reconsideration resulting in upholding of original coverage determination or redetermination. This should be a numeric field.

Section VIII. Call Center Measures

Part D Sponsors will report several data elements related to customer service center calls related to Part D. This information will be utilized to monitor plan performance. These reporting requirements were designed to provide flexibility around each Part D Sponsor's call center structure. CMS requests data is submitted at the most detailed level available (e.g., Plan level would be the most detailed, and preferred whenever available) and Part D Sponsors must note in HPMS the level of reporting provided. Also, while call centers may track other metrics such as calls related to medical care, calls related to Part D in any manner should be tracked separately for inclusion in this reporting requirement.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	May 31	August 31	November 30	February 28

Data elements to be entered into the HPMS at the Part D Sponsor level or Plan level if available:

A. For the time period specified above, provide the total number of inbound Part D connections abandoned. This will be a numeric field. For Part D Sponsors that cannot separate abandoned Part D calls from other calls, the total number of inbound connections abandoned will be reported and also the total number of inbound calls for the customer service center, during the reporting period specified,
B. For the time period specified above, provide the total number of inbound Part D calls. This will be a numeric field.
C. For the time period specified above, provide the average speed of answer for Part D calls. This is defined as the time it takes to get an inbound call connected to a customer service representative prior to being placed into a hold queue (e.g., from connection to welcome message). This will be a numeric field (mm:ss).
D. For the time period specified above, provide the number of Part D calls answered in ≤30 seconds. This will be a numeric field.
E. For the time period specified above, provide the average hold time for Part D calls (e.g., time from entering a hold queue to being addressed by a customer service representative). This will be a numeric field (mm:ss).

Section IX. Overpayment

Part D Sponsors will be responsible for reporting data related to overpayments associated with Part D benefits. An overpayment occurs when a Part D Sponsor erroneously makes a payment in excess of the amount due and payable under the Part D drug benefit. Examples would include overpayments a plan makes to pharmacies, sub-contractors, or PBMs for claims payment. This information is necessary to ensure that overpayments are being identified and recouped appropriately.

Reporting timeline:

	Period 1	**Period 2**
Reporting Period	January 1 - June 30	July 1 – December 31
Data due to CMS/HPMS	August 31	February 28

Data elements to be entered into the HPMS at the Plan level:

A. For the time period identified above, provide the total overpayment dollars identified to be recouped by the Plan (i.e., any funds the Plan recovers from any entity it has overpaid, including, pharmacies, providers, Pharmaceutical Benefit Managers, etc.) This should be a currency field.
B. For the time period identified above, provide the total overpayment dollars recouped by the Plan. This should be a currency field.

Section X. Pharmaceutical Manufacturer Rebates, Discounts, and Other Price Concessions

Part D Sponsors will be responsible for reporting multiple data elements related to rebates. These data will be monitored as components of a Part D Sponsor's operational costs. CMS recognizes the importance of maintaining confidentiality of these records. CMS will do everything within its authority to limit access to those who have appropriate use or oversight role and will track those who have accessed these records.

Rebates, discounts, and other price concessions will be reported at the CMS Part D Sponsor level. Reporting will not be combined by the subcontractor PBM to include multiple Part D Sponsor data. For example: (1) national Part D sponsors with multiple regional plans contracting independently or through a PBM will report rebates from the level of the national Part D sponsor; (2) regional or local Part D sponsor whether utilizing subcontractor PBM or not report at the Part D sponsor specific level; (3) PBM providing Part D coverage outside of a subcontractor role will report rebates at the PBM level. Rebate information should be summarized for each drug, rolled up to include multiple strengths, package sizes, dosage formulations, or combinations.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	September 30	December 31	March 31	June 30

Data files to be uploaded through the HPMS at the CMS Part D Sponsor level as specified above:

A. Part D Sponsors will provide an Excel file (filename=REBATES_(SPONSORNAME)_(2006Q#).XLS, replacing '(SPONSORNAME)' with the Part D Sponsor's name and '(2006Q#)' with the year and quarter number) with the first row of data containing all included Contract IDs in separate columns and then include information related to actual rebate dollars starting in the second row using the following columns in the order as listed (i.e., column headings will be listed in row 2 and data starting in row 3):

1. MFG_NAME: For each rebate, provide the contracting manufacturer name. This should be a character field.
2. BRAND_NAME: For each rebate, provide the brand name. This should be a character field.
3. REBATE_REC: For each unique manufacturer/brand name combination, provide the rebate amount received in the reporting period specified. This should be a numeric (currency) field.
4. PEND_REBATE: For each unique manufacturer/brand name combination, provide the rebate amount requested for the reporting period specified but not yet received (if applicable). This should be a numeric (currency) field; enter zero if none.
5. PRIOR_REBATE: For each unique manufacturer/brand name combination, provide the rebate amount received that is associated with a prior reporting period (if applicable). This should be a numeric (currency) field; enter zero if none.

Example:

H1234	H1235			
MFG_NAME	BRAND_NAME	REBATE_REC	PEND_REBATE	PRIOR_REBATE
<Data>	<Data>	$X	$X	$X

B. It is expected that the file specified above will summarize most rebate information. However, for all non-rebate discounts, price concessions, or other value adds such as gift-in-kind or other programs (e.g., coupons or disease management programs specific to a Part D Sponsor), Part D Sponsors will provide an additional Excel file (filename=DISCOUNTS_(SPONSORNAME)_(2006Q#).XLS, replacing '(SPONSORNAME)' with the Part D Sponsor's name and '(2006Q#)' with the year and quarter number) with the first row of data containing all included Contract IDs in separate columns and then include information related to the discounts, price concessions, or other value adds starting in the second row using following columns in the order as listed (i.e., column headings will be listed in row 2 and data starting in row 3):

1. MFG_NAME: List the name of each manufacturer for whom there is an associated discount, price concession, or other value add. This should be a character field.
2. DESCRIPTION: Describe the discount, price concession, or other value add. This should be a character field.
3. VALUE: Provide the value of the discount, price concession, or other value add. This should be a currency field.
4. JUSTIFICATION: For each discount, price concession, or value add, provide a justification for receipt. This should be a character field.

Example:

H1234	H1235		
MFG_NAME	DESCRIPTION	VALUE	JUSTIFICATION
<Data>	<Data>	$X	<Data>

Section XI. Licensure and Solvency, Business Transactions and Financial Requirements

Title I, Part 423, Subpart I includes statutory regulations regarding Licensure and Solvency. Part D PDP Sponsors will be responsible for reporting multiple data elements and documentation related to their licensure and solvency and other financial requirements. Some data will be entered into the HPMS and other information will be mailed directly to CMS. These data will be used to ensure Part D PDP Sponsors continue to be fiscally solvent entities.

Reporting timeline:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31	Fiscal Year
Data due to CMS/HPMS	May 15	August 14	November 14	February 14	120 days after the end of the Plan's fiscal year

For materials that need to be mailed directly to CMS, please send them to the address below:

Centers for Medicare and Medicaid Services
Center for Beneficiary Choices
Medicare Drug Benefit Group
Division of Finance and Operations
7500 Security Boulevard
Baltimore, MD 21244

Financial and Solvency Requirements at the Part D PDP Sponsor Level:

A. According to the quarterly time periods specified above, Part D PDP Sponsors that are licensed will mail the following completed Health Blank form pages directly to CMS:
    - Jurat
    - Assets
    - Liabilities, Capital and Surplus
    - Statement of Revenue and Expenses
    - Capital and Surplus Account
    - Cash Flow
B. According to the quarterly time periods specified above, Non-licensed Part D PDP Sponsors will mail un-audited financial statements, which convey the same information contained in the Health Blank form, directly to CMS.
C. According to the quarterly time periods specified above, Non-licensed Part D PDP Sponsors will mail documentation showing that an insolvency deposit of $100,000 is being held in accordance with CMS requirements by a qualified financial institution.
D. According to the quarterly time periods specified above, Part D PDP Sponsors not licensed in any state must submit a funding for projected losses worksheet to show they possess allowable sources of funding to cover projected losses for the greater of: 7.5% of the aggregated projected target amount for a given year or resources to cover 100% of any projected losses in a given year. This documentation should also take into account modifications of previous projections and show how they arrived at the aggregated projected target amount.
E. All Part D PDP Sponsors will mail a copy of their independently audited financial statements (which are statutory based or GAAP based) with a management letter within one hundred twenty days following their fiscal year end directly to CMS.
F. All Part D PDP Sponsors will mail a copy of an Actuarial Opinion by a qualified actuary within one hundred twenty days following their fiscal year end directly to CMS. The opinion should address the assumptions and methods used in determining loss revenues, actuarial liabilities, and related items.

Data elements to be entered into HPMS at the Part D Sponsor Level:

A. Total assets as of the end of the quarterly reporting period identified above. This should be a currency field.
B. Total liabilities as of the end of the quarterly reporting period identified above. This should be a currency field.
C. Total cash as of the end of the quarterly reporting period identified above. This should be a currency field.
D. Total cash equivalents as of the end of the reporting period identified above. This should be a currency field.
E. Total current assets as of the end of the quarterly reporting period identified above. This should be a currency field.
F. Total current liabilities as of the end of the quarterly reporting period identified above. This should be a currency field.
G. Total revenue as of the end of the quarterly reporting period identified above. This should be a currency field.
H. Total expenses as of the end of the quarterly reporting period identified above. This should be a currency field.
I. Total administrative expense as of the end of the quarterly reporting period identified above. This should be a currency field.
J. Total net income as of the end of the quarterly reporting period identified above. This should be a currency field.
K. Drug benefit expenses (excluding administrative expenses) as of the end of the quarterly reporting time period. Drug benefit expenses are paid claims costs which would be comprised of negotiated costs and dispensing fees less member share. This should be a currency field.
L. Drug benefit revenues as of the end of the quarterly reporting period. Drug benefit revenues would include premiums, CMS subsidies, rebates and other reinsurance. This should be a currency field.

Appendix

Table 1. Summary of Reporting Elements

Note: this summary table is for quick reference use only. Please refer to the respective detailed sections for full definitions, timelines, reporting level, and submission procedures.

Section	Element	Format	Frequency	HPMS
Enrollment and Disenrollment	Number of beneficiaries enrolled	Numeric	Quarterly	Yes
	Number of beneficiaries who disenrolled for any reason	Numeric	Quarterly	Yes
	Number of beneficiaries who were involuntarily disenrolled for failure to pay their premium	Numeric	Quarterly	Yes
	Number of beneficiaries who were involuntarily disenrolled from the Plan for disruptive behavior	Numeric	Quarterly	Yes
	Number of beneficiaries who were disenrolled from the Plan for providing false or incomplete information regarding other coverage	Numeric	Quarterly	Yes
	Number of beneficiaries who were disenrolled from the Plan because of death	Numeric	Quarterly	Yes
	Number of beneficiaries who were disenrolled from the Plan because of moving from the service area	Numeric	Quarterly	Yes
Reversals	Total number of out-of-cycle pharmacy transactions with reversal as the final disposition	Numeric	Quarterly	Yes
Medication Therapy Management Programs (MTMP)	Number of beneficiaries who met the criteria for the MTMP	Numeric	Semi-annually	Yes
	Number of beneficiaries who participated (as defined by the Part D Sponsor) in the MTMP at any point during the specified time period	Numeric	Semi-annually	Yes
	Number of beneficiaries who disenrolled (as defined by the Part D Sponsor) from the MTMP at any time during the specified time period	Numeric	Semi-annually	Yes
	Number of beneficiaries who declined the offer to participate in the MTMP	Numeric	Semi-annually	Yes
	Total prescription cost of all medications for all beneficiaries participating in the MTMP (as of the last day of the reporting period specified) on a per MTMP beneficiary per month basis	Currency	Semi-annually	Yes
Generic Dispensing Rate	Number of paid claims for generic drugs (regardless of days supply)	Numeric	Quarterly	Yes
	Total number of paid claims (regardless of days supply)	Numeric	Quarterly	Yes
Grievances	Number of fraud and abuse grievances received	Numeric	Quarterly	Yes
	Number of enrollment/disenrollment grievances received	Numeric	Quarterly	Yes
	Number of benefit package grievances received	Numeric	Quarterly	Yes
	Number of pharmacy access/network grievances received	Numeric	Quarterly	Yes
	Number of marketing grievances received	Numeric	Quarterly	Yes
	Number of customer service grievances received	Numeric	Quarterly	Yes
	Number of confidentiality/privacy grievances received	Numeric	Quarterly	Yes
	Number of other grievances received	Numeric	Quarterly	Yes

Section	Element	Format	Frequency	HPMS
Prior Authorization, Step Edits, and Non-Formulary Exceptions	Number of pharmacy transactions rejected due to failure to complete step edit requirements	Numeric	Quarterly	Yes
	Number of pharmacy transactions rejected due to need for prior authorization (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations requested for formulary medications (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations approved for formulary medications (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations requested for non-formulary medications (not including early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations approved for non-formulary medications (not including early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations requested for tier exceptions (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
	Number of prior authorizations approved for tier exceptions (not including first pass step therapy edits or early refills)	Numeric	Quarterly	Yes
Appeals	Number of appeals submitted for **standard** redetermination	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination that were granted **expedited** status	Numeric	Quarterly	Yes
	Number of appeals submitted for **standard** redetermination withdrawn by the enrollee	Numeric	Quarterly	Yes
	Number of appeals submitted for **expedited** redetermination withdrawn by the enrollee	Numeric	Quarterly	Yes
	Number of redeterminations resulting in reversal of original decision	Numeric	Quarterly	Yes
	Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **coverage determination**	Numeric	Quarterly	Yes
	Number of appeals submitted for IRE reconsideration due to inability to meet timeframe for **redetermination**	Numeric	Quarterly	Yes
	Number of IRE decisions for **standard** reconsideration resulting in reversal of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **expedited** reconsideration resulting in reversal of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **standard** reconsideration resulting in upholding of original coverage determination or redetermination	Numeric	Quarterly	Yes
	Number of IRE decisions for **expedited** reconsideration resulting in upholding of original coverage determination or redetermination	Numeric	Quarterly	Yes

Section	Element	Format	Frequency	HPMS
Call Center Measures	Total number of inbound Part D connections abandoned	Numeric	Quarterly	Yes
	Total number of inbound Part D calls	Numeric	Quarterly	Yes
	Average speed of answer for Part D calls	Numeric	Quarterly	Yes
	Number of Part D calls answered in ≤30 seconds	Numeric	Quarterly	Yes
	Average hold time for Part D calls	Numeric	Quarterly	Yes
Overpayment	Total overpayment dollars identified to be recouped by the Plan	Currency	Semi-Annually	Yes
	Total overpayment dollars recouped by the Plan	Currency	Semi-Annually	Yes
Rebates	REBATES_(SPONSORNAME)_(2006Q#).XLS	MS Excel	Quarterly	Yes
	DISCOUNTS_(SPONSORNAME)_(2006Q#).XLS	MS Excel	Quarterly	Yes
Licensure and Solvency	Licensed Part D PDP Sponsors will submit Completed Health Blank form pages: Jurat, Assets, Liabilities, Capital and Surplus, Statement of Revenue and Expenses, Capital and Surplus Account, and Cash Flow OR Non-licensed Part D PDP Sponsors will submit un-audited financial statements	Mailed to CMS	Quarterly	No
	Documentation showing that an insolvency deposit of $100,000 is being held (for non-licensed Part D PDP Sponsors only)	Mailed to CMS	Quarterly	No
	Funding for projected losses worksheet (for non-licensed Part D PDP Sponsors only)	Mailed to CMS	Quarterly	No
	Independently audited financial statement with a management letter	Mailed to CMS	Yearly (fiscal)	No
	Copy of an Actuarial Opinion by a qualified actuary	Mailed to CMS	Yearly (fiscal)	No
	Total assets	Currency	Quarterly	Yes
	Total liabilities	Currency	Quarterly	Yes
	Total cash	Currency	Quarterly	Yes
	Total cash equivalents	Currency	Quarterly	Yes
	Total current assets	Currency	Quarterly	Yes
	Total current liabilities	Currency	Quarterly	Yes
	Total revenue	Currency	Quarterly	Yes
	Total expenses	Currency	Quarterly	Yes
	Total administrative expense	Currency	Quarterly	Yes
	Total net income	Currency	Quarterly	Yes
	Drug benefit expenses (excluding administrative expenses)	Currency	Quarterly	Yes
	Drug benefit revenues	Currency	Quarterly	Yes